Chronic Disease / Epilepsy and Neurological Disorders Program Monitoring Plan

I. Program Overview

The NC Epilepsy and Neurological Disorders program is mandated by the state legislature (G.S. 130A-223) and administered by DHHS Rules 15A NCAC 16A .0500. The purposes of the Epilepsy and Neurological Disorders program are to reduce the further risk and consequences to persons diagnosed with epilepsy and other neurological disorders by providing public, patient and professional education; to help patients find a medical home; and to prevent recurrent seizures and their sequelae by purchasing anti-convulsant medications for low income persons. This program is available to persons meeting the eligibility requirements for the State Epilepsy and Neurological Disorders Program when there is no other source of reimbursement. However, all persons are eligible for the educational component of this program. The program is state funded.

The State of NC has formal agreements with four local health departments - Cumberland, Jackson, New Hanover and Pitt. These local health departments provide clinical services to persons at risk or diagnosed with epilepsy or other neurological disorders and provide anticonvulsant medications at Medicaid rates to persons diagnosed with epilepsy for which anticonvulsant medications are prescribed. These persons must meet financial eligibility criteria in accordance with the Purchase of Medical Care Rules 15A NCAC 24A and have no other source of third party reimbursement for these medications. The local health departments must determine the eligibility of individual patients by completing and retaining a copy of both the Financial Eligibility Form (DHHS 3014) and the Authorization Request Form (DHHS 3056) on each potentially eligible person (See Attachments 1 and 2). These are purchase of service arrangements.

Through a contract with Wake Forest University Epilepsy Information Service (WFUEIS), the Epilepsy and Neurological Disorders Program provides access to public, patient and professional education; clinical services; and access to anti-convulsant medications for eligible persons. These persons must meet financial eligibility criteria in accordance with the Purchase of Medical Care Rules 15A NCAC 24A and have no other source of third party reimbursement for these medications. The Wake Forest Epilepsy Information Service also determines the eligibility of individual patients by completing and retaining a copy of both the Financial Eligibility Form (DHHS 3014) and the Authorization Request Form (DHHS 3056) on each potentially eligible person. The Wake Forest Epilepsy Information Service provides these statewide services through a toll-free telephone line - 1-800-642-0500. This is a financial assistance contract.

II. Monitoring Process Overview

All contractors must complete the Epilepsy Medication Quarterly Report form (DHHS 3523 - see Attachment 3). This report is due to the Epilepsy Program Administrator quarterly, by the 10th of October, January, April and July. Wake Forest University Epilepsy Information Service must also submit monthly Contract Expenditure Reports (DHHS 2481 – see Attachment 4) to the Epilepsy Program Coordinator. Local Health Departments must submit Local Expenditure Report (DHHS 2949) monthly to the Office of the Controller, 2025 Mail Service Center, Raleigh, NC, 27699-2025.

The purpose of completing these forms is to provide financial and statistical information for reimbursement to agencies participating in the Epilepsy Medication Component of the Epilepsy Medication Component of the Epilepsy and Neurological Disorders Program. The Epilepsy Program Administrator reviews the Contract Expenditure Report monthly. The Epilepsy Program Administrator reviews the Epilepsy Medication Quarterly Report form each quarter.

The Epilepsy Program Administrator has periodic telephone and email contact with the contractors and conducts an annual site visit at Wake Forest University Epilepsy Information Service in March of each year. To schedule the visit, the Epilepsy Program Administrator contacts the WFUEIS Program Administrator. During the visit, the Epilepsy Program Administrator meets first with the program director, then with the program staff to review and discuss eligibility guidelines, issues or concerns for the program and any other monitoring items deemed necessary. The Epilepsy Program Administrator completes the Epilepsy and Neurological Disorders Program Site Visit Form (see Attachment 5).

III. Monitoring Schedule

The Epilepsy Program Administrator monitors reports monthly and quarterly as described above. Site visits are conducted annually as described above.

IV. Monitoring Tools

There are three monitoring tools for the Epilepsy and Neurological Disorders Program.

- Epilepsy Medication Quarterly Report form (DHHS 3523 - see Attachment 3)
- Contract Expenditure Reports (DHHS 2481 – see Attachment 4)
- Epilepsy and Neurological Disorders Program Site Visit Form (See Attachment 5)

V. Monitoring Documentation

After completion of the site visit, the Epilepsy Program Administrator completes the Epilepsy and Neurological Disorders Program Site Visit Form (see Attachment 5). The Epilepsy Program Administrator mails a copy of the site visit report to the contractor and files the original in the Epilepsy Program Administrator's office.

VI. Follow up

To date, Wake Forest University Epilepsy Information Service has not had any findings to report. Should that occur in the future, the Epilepsy Program Administrator would work with Wake Forest University Epilepsy Information Service to develop a corrective action plan.

Attachment I

FINANCIAL ELIGIBILITY APPLICATION

Purchase of Medical Care Services
DHHS – Controller's Office
1904 Mail Service Center • Raleigh, NC 27699-1904

FOR POMCS USE ONLY

1. Last Name | First Name | MI

2. Patient SS #

3. Date of Birth (Month / Day / Year)

4. Sex ☐ 1. Male ☐ 2. Female

5. Race ☐ 1. White ☐ 2. Black ☐ 3. American Indian ☐ 4. Asian ☐ 5. Native Hawaiian/Other Pacific Islander ☐ 6. Unknown

Ethnicity: Hispanic or Latino Origin? ☐ Yes ☐ No ☐ Unknown

6. Preferred Language _____ Select from the list on the back of this form

7. County of Residence

8. Address | Street or RFD

9. City | State | Zip Code

10. Telephone Number: Home | Work

11. Program

12. Case Number

13. NC Resident ☐ Yes ☐ No If **yes**, select one of the following:
(Applicants to ADAP need only answer Y/N)
☐ 1. US citizen who lives in NC and intends to make NC his permanent home
☐ 2. Non citizen who has applied for US citizenship. INS documentation required
☐ 3. Non citizen who has a permanent resident visa or has applied for one (INS documentation required)
☐ 4. Migrant farmworker according to the federal definition
Migrant (Farmworker) Health Program Eligibility Application (DHHS 3753) required
Note: Migrant farmworker status meets the residency requirement for all POMCS programs

14. **Countable** Family Members
Number of Adults _____
Number of Children _____
Total Number _____

15. Earliest Requested Date of Program Coverage (Month / Day / Year)

INCOME FORMULAS: Regular (**R**) – Continuously employed wage earners list income for the 12 months before the date of application **or** the requested date of coverage, whichever is earlier. Unemployment (**U**) – Wage earners unemployed at the time of application or for 30 consecutive days during the previous 12 months list income for 6 months before and after the date of application **or** the requested date of coverage, whichever is earlier. Cancer Program and ADAP are based on gross income. Must report Gross and Net Income for ADAP.

16. Complete for **All** Countable Family Members

Name	Relationship to Patient	Income Formula (R or U)	List all Employers or Sources of Income/Reason for None for **12 Month Period**	Dates From	Dates To	Gross Income	Income After Tax *(Not for ADAP or Cancer Program)*

17. Explanations: Dates unemployed; means of support if income is low; etc.

18. **Annual Gross Income** (Stop here for Cancer Program ***only***. For ADAP include Annual Gross Income and Annual Net Income.)

Federal, State & Soc. Sec. Tax

Income After Taxes

Total Income After Taxes (Sum of Both Lines) $_____

Medical expenses paid or incurred during past 12 months not covered by a third party nor requested for program coverage $_____

Other deductions: (Specify)_____ $_____

Total Deductions $_____

Annual Net Income (All Other Programs) $_____

19. Eligibility for Other Programs Medicaid ID # _____

Medicare: ☐ Part A ☐ Part B ☐ Part D Medicare # _____

Social Security LIS Application ☐ Yes ☐ No

VA Benefits: Are you a veteran? ☐ Yes ☐ No

Did you actively serve in any branch of the military for over 180 days? ☐ Yes ☐ No

Did you receive an honorable or general discharge? ☐ Yes ☐ No

20. Was patient's problem caused by an accident? ☐ Yes ☐ No

If yes, liability compensation is ☐ Pending ☐ Awarded ☐ Ruled Out

Give attorney's name, address and phone number in block #17

21. HEALTH INSURANCE COVERAGE Provide complete insurance information and copies of insurance cards for **all** countable family members.

Company _____ Company _____

Policy No. _____ Policy No. _____

Claims Address _____ Claims Address _____

_____ Telephone _____ _____ Telephone _____

Policyholder _____ Policyholder _____

Is patient covered? ☐ Yes ☐ No Is this an **HMO**? ☐ Yes ☐ No Is patient covered? ☐ Yes ☐ No Is this an **HMO**? ☐ Yes ☐ No

22. I hereby certify that I have read or the interviewer has read to me the terms and conditions contained on the back of this form and that I agree to comply with them. I also certify that I have been provided opportunity to ask the interviewer questions about these terms and conditions and that I understand the answers I was given.

Applicant's Signature | Relationship to patient | Date

23. I certify that I have explained the terms and conditions contained on the back of this form to the applicant and have witnessed his signature.

Type or Print Interviewer's Name | Agency Name | Date

Interviewer's Signature | Street Address/P.O. Box | Phone

City/State/Zip Code

Attachment I

INSTRUCTIONS

Purpose: To collect information required for the determination of program eligibility.

An interviewer completes this form when a service authorization is requested unless a current form is already on file. Once determined, eligibility generally extends for 12 months. The exception is new applications received during the annual renewal periods for the HIV Medication (January-March) and Kidney (April-June) programs. These may extend for up to 15 months. A new form is required when changes in countable family members and/or income occur.

Preparation: Consult Purchase of Medical Care Services manual for information on residency requirements, income calculation and expense documentation. Income may be entered in the column labeled "Gross Income" or the one labeled "Income After Taxes". The same income should not be entered in both columns. Both Net and Gross Income need to be completed for ADAP.

Instructions for Completing Certain Items on this Form:

6. Select one of the following languages and enter the 2 letter code in block 6 on the front of this form.

Arabic (AR)	Gujarati (GU)	Miao (MI)	Serbo-Croatian (SC)
Cambodian (CA)	Hindi (HI)	Mon-Khmer (MK)	Spanish (SP)
Chinese (CH)	Hmong (HM)	**Other (OT)**	Tagalog (TA)
English (EN)	Hungarian (HU)	Persian (PE)	Thai (TH)
French (FR)	Italian (IT)	Poland (PO)	Urdu (UR)
French Creole (FC)	Japanese (JA)	Portuguese (PG)	Vietnamese (VI)
German (GE)	Korean (KO)	Portuguese Creole (PC)	
Greek (GR)	Laotian (LA)	Russian (RU)	

14. **Countable family members** are related to the applicant by blood, marriage or adoption, live in the same household **and** share a financial responsibility.

16. **Earned income** must be documented if medical expense deductions exceed $3,000 or an inpatient stay is requested. Medical expense deductions must be documented in full when they exceed $3,000.

18. **Deductible medical expenses** are those paid or incurred by a countable family member during the 12 months prior to the earliest date of service. Expenses paid for by another party or requested for coverage by a program cannot be used as deductions. The Cancer Program and ADAP are based on gross income and do not allow for deductions of any kind.

Submit this application and documentation as required to the following address: DHHS Office of the Controller, Purchase of Medical Care Services, 1904 Mail Service Center, Raleigh NC 27699-1904.

Additional forms may be ordered by faxing a request to 919-733-0352 or calling 919-855-3672.

TERMS AND CONDITIONS FOR APPLICANT

I agree to notify the interviewer within 30 days about any changes in the patient's address, financial resources, expenses, family situation, or health insurance coverage that might affect his or her eligibility for Department payment programs. I certify that the information I have provided is a true and complete statement of facts according to my best knowledge and belief. I understand that information provided may be checked by a state reviewer, and I agree to provide the financial records required to carry out this investigation. I also understand that my employer may be asked to verify information concerning my income.

I assign insurance benefits to the Department. I agree to repay the Department any money I receive from insurance or liability settlements for services or appliances which the Department purchased for me. I understand that such payments should be made to the Department within 45 days of the date that I receive them and that the amount paid to the Department should not exceed the amount the Department paid the provider. I further agree that failure to repay assigned insurance benefits to the Department is a reason for denial of future service requests to the Department until such amounts have been repaid.

I understand that my eligibility for Medicaid will be checked. I hereby authorize and agree to a free exchange of information between the Division of Medical Assistance and the Department of Health and Human Services relating to financial information and the amount of services provided by either program

I hereby authorize the interviewer and service providers to release to the Department and its affiliate programs the information provided on this form and also the medical records of the patient which pertain to medical services or appliances for which reimbursement is being sought from the Department.

I also authorize release of this information to the county health department where the patient resides and/or receives services. I also authorize release of the information on this form to all health departments and hospitals in North Carolina. These disclosures shall be made for purposes of determining the patient's eligibility for Department payment programs and for conducting program evaluation.

I voluntarily give my consent to the terms of this release. My consent shall be valid for a period of one year. I further understand that I may revoke my consent at any time. Such revocation does not affect the validity of my consent for information disclosed prior to the revocation.

I understand that I may appeal the denial of this financial eligibility application. Information on how to appeal the denial can be obtained by writing to the N.C. DHHS Office of the Controller, Purchase of Medical Care Services, 1904 Mail Service Center, Raleigh NC 27699-1904. I understand that payment by the Department for health care provided to the patient is dependent upon the patient meeting all financial and medical requirements, timely submission of authorization requests and claims, and the availability of funds.

WEBSITE: www.ncdhhs.gov/control/pomcs/pomcs.htm

Attachment II

AUTHORIZATION REQUEST

Purchase of Medical Care Services
DHHS – Controller's Office

Read Instructions on Back

1. Last Name | First Name | MI

2. Patient SS # ___ — ___ — ____

3. Date of Birth (Month / Day / Year)

4. Sex ☐ 1. Male ☐ 2. Female

5. Race ☐ 1. White ☐ 2. Black ☐ 3. American Indian ☐ 4. Asian ☐ 5. Native Hawaiian/Other Pacific Islander ☐ 6. Unknown

Ethnicity: Hispanic or Latino Origin? ☐ Yes ☐ No ☐ Unknown

6. Preferred Language _____ Select from the list on the back of this form

7. County of Residence

8. Address | Street or RFD

9. City | State | Zip Code

10. Telephone # Home | Work

11. Name of Parent or Guardian or Alternate Contact | Last | First | Middle | Phone #:

12. Program

13. Authorization Number

14. POMCS Case Number

15. Hospital or Provider of Requested Service
Contact:
Address:
Phone #:

16. Requested dates of service

17. Service is authorized for the following dates:

18. Diagnostic Code/Diagnosis: Primary | Secondary

19. Insurance or Third Party *(Attach copies of all Insurance Cards)* | Policy # | Policyholder | Claims Address

Does this policy cover this service? ☐ Yes ☐ No

Does this policy provide **complete** coverage? ☐ Yes ☐ No Is this an HMO? ☐ Yes ☐ No **If an HMO, documentation is required. See reverse.**

20. COMPLETE FOR CANCER TREATMENT REQUESTS
A. Estimated five-year survival rate: _____%
B. Recurrent disease: ☐ Yes ☐ No If yes, attach statement about history.
C. Stage of disease or TNM classification_____
D. For Cervical Intraepithelial Neoplasia, check appropriate box: ☐ mild ☐ moderate ☐ severe

21. COMPLETE FOR ALL HIV REQUESTS
A. CD_4 Count _____
Date _____/_____/_____
B. Viral Load _____
Date_____/_____/_____

22. CHECK SERVICE REQUESTED **All programs do not cover all types of service.**
A. ☐ Inpatient Admission for _____ days
B. ☐ Inpatient Extension for _____ days
C. ☐ Outpt. (Hosp., Dial, FASC) for _____ visits
D. ☐ Physician's Office for _____ visits
E. ☐ Therapy (PT, OT, SP) Tot. #____ Freq. _____ Sess. Lgth. _____
F. ☐ Drugs related to program covered condition
G. ☐ Appliances/supplies. Give estimated cost in #23
H. ☐ Formula ____ oral ____ enteral
I. ☐ Home Nursing Care Tot. #_____ Freq. _____
J. ☐ Residential Care for _____ days
K. ☐ Nutri. Counseling Tot. #_____ Freq. _____

23. Describe service requested. Give estimated cost for **each** appliance. Required for EHDI Initial Hearing Aid.

24. **Ship equipment or medications to:**
Street Address: | State Rd/RFD:
City: | State: | Zip Code:

25. Enter names and addresses of providers to whom a copy of approved Authorization should be sent for billing purposes. **Do not include those listed in blocks 15 and 29.**

26A. Type or print physician's name

26B. Physician's Signature

27. Other Clinician's Signature

28. FOR ALL HIV REQUESTS
Clinician's Information:
Phone #:
Fax #:
DEA #:
NC License #:

29. Requesting Office
Agency:
Contact:
Address:
Phone #:
Date: (Month / Day / Year)

DHHS 3056 (Revised 12/07)
Purchase of Medical Care Services (Review 05/07)

Attachment II

INSTRUCTIONS

PURPOSE

This form is used to request authorization for reimbursement from the following programs: Adult Cystic Fibrosis, Cancer Control, Children's Special Health Services, EHDI Initial Hearing Aid, HIV Medications, Kidney and Sickle Cell. As of April 1999, the Migrant Health Program no longer requires Authorization Requests.

To qualify for payment, an applicant must be eligible for the program and an Authorization Request must be received within one year after the date of service. Processing time is reduced when this form is legible and complete. If requested, additional information must be received within one year after the date of service or within 30 days of notification, whichever is later. Incomplete forms will be returned.

Requests under EHDI-Initial Hearing Aid for Infants and Toddlers must be submitted by the third birthday. **Authorization Requests should be submitted without documentation if necessary to meet deadlines.** Requests will not be processed until all information is received.

INSTRUCTIONS FOR COMPLETING CERTAIN ITEMS ON THIS FORM

6. Select one of the following languages and enter the 2 letter code in block 6 on the front of this form.

Arabic (AR)	Gujarati (GU)	Miao (MI)	Serbo-Croatian (SC)
Cambodian (CA)	Hindi (HI)	Mon-Khmer (MK)	Spanish (SP)
Chinese (CH)	Hmong (HM)	Other (OT)	Tagalog (TA)
English (EN)	Hungarian (HU)	Persian (PE)	Thai (TH)
French (FR)	Italian (IT)	Poland (PO)	Urdu (UR)
French Creole (FC)	Japanese (JA)	Portuguese (PG)	Vietnamese (VI)
German (GE)	Korean (KO)	Portuguese Creole (PC)	
Greek (GR)	Laotian (LA)	Russian (RU)	

10., 15., 28., 29. Include area code with phone number.

12. Specify program applied for.

13., 17. For POMCS use only. Do not complete these items.

18. Provide ICD-9 code if available. **Diagnosis should correspond to requested service.**

19. Provide complete insurance information. Attach copies of all insurance cards. Submit HMO denial or statement of benefits **if** HMO does not cover or partially covers requested service.

20. For cancer treatment only. Do not complete for diagnostic requests.

21. For HIV Program only. Provide most recent values.

22. **All Programs Do Not Cover All Types of Service**. Refer to individual program guidelines regarding coverage limitations.

    ALL PROGRAMS
    - Use separate forms for different types of service
    - Use separate forms for each inpatient admission
    - Use separate forms for each DME provider

    CANCER CONTROL PROGRAM
    - Use separate forms for diagnostic and treatment requests
    - Designate follow up visits

23. Medical documentation is sometimes required. Refer to individual program guidelines regarding specific requirements.

24. Equipment is shipped to patient's home unless alternate address is listed here.

25. Include CAP case manager's name, address and signature if patient covered by CAP Medicaid.

26. Reserved for physician's name and signature. Cancer Control Program requires signature of attending physician. Children's Special Health Services requires original signature of program rostered physician. HIV Program allows signature of PA or Nurse Practitioner.

27. Enter signature of clinician, PA or practitioner specified by program.

28. For HIV Program, enter clinician's telephone number, fax number, DEA number and NC License number.

MAIL REQUESTS TO: Purchase of Medical Care Services
DHHS-Office of the Controller
1904 Mail Service Center
Raleigh, NC 27699-1904

Faxed Authorization Requests are not given priority. Requesting offices should contact POMCS regarding the need to expedite a request.

BILLING INSTRUCTIONS

After a service has been authorized and provided, claims should be submitted to the POMCS Claims Processing Unit, DHHS-Office of the Controller, 1904 Mail Service Center, Raleigh, NC 27699-1904. All third party payors must be billed. Providers must wait for payment or denial or wait up to six months, whichever comes first, before billing a POMCS program. All claims must be received within one year after the date of service in order to be paid. Additional billing information is available upon request.

HOW TO ORDER THIS FORM

Additional forms may be orderd by faxing a request to 919-733-0352 or calling 919-855-3672.

WEBSITE: www.ncdhhs.gov/control/pomcs/pomcs.htm

Attachment III

North Carolina Department of Health and Human Services
Division of Public Health

Epilepsy Medication Quarterly Report
Epilepsy and Neurological Disorders Programs (ENDP)

1. Agency **2. Fiscal Year**

3. Prepared by: **4. Phone**

5. Quarterly Reporting: ____ **July - September** ____ **October – December**
____ **January - March** ____ **April – June**

6. Patients with Epilepsy participating in medication reimbursement component of ENDP:

a) Name	b) Age	c) COR	d) Medication Name	e) Amount $ Charge to ENDP
f) Subtotal (This Page)				
g) Grant Total (Of all Pages)				

Attachment III

Purpose: To provide financial and statistical information for reimbursement to agencies participating in the Epilepsy Medication Component of the Epilepsy Medication Component of the Epilepsy and Neurological Disorders Program (ENDP)

INSTRUCTIONS

Preparation:

1. Enter the complete name of agency completing the report.
2. Enter the fiscal year the report covers.
3. Enter the name of the individual preparing the report.
4. Enter the agency's telephone number.
5. Place a check mark beside the quarter for which the report if filed.
6. Enter the information about patient's participating in the Epilepsy Medication Component for whom reimbursement is requested.

    A. Enter the full name of the patient served.
    B. Age-enter the age of patient at last birthday.
    C. Enter the 3-digit County of Residence code for the patient.
    D. Enter the name(s), strength and dose form (tablets, liquid etc.) Of Medications for which reimbursement is being requested. (More than one line may be needed for the patient).
    E. Enter the amount that the agency is charging against the EDNP contract for medications provided to the patient during the quarter.
    F. Sub-total – enter the total dollars charging the ENDP of all patients reported on this page.
    G. Grand Total – enter the total of all individual page sub-totals.

Distribution:

This report is due quarterly, by the 10th of October, January, April and July, but your **expenditure** reports are due **monthly** as explained below.

Health Department agencies submit this report quarterly to:

Epilepsy Program
Division of Public Health
1915 Mail Service Center
Raleigh, NC 27699-1915
Courier 56-20-11

Health Department agencies submit DHHS 2949 Local Expenditure Report monthly to:

Office of the Controller
2025 Mail Service Center
Raleigh, NC 27699-2025

Private agencies submit this report quarterly and DHHS 2482 Expenditure Report monthly to:

Epilepsy Program
Division of Public Health
1915 Mail Service Center
Raleigh, NC 27699-1915

Disposition: Destroy five (5) years after last audit to which report applies

Additional forms may be ordered by calling (919) 707-5376. This number will forward to voice mail if no one is available to take the call. Please leave your name, number, agency name, number of forms (summary and continuation sheets) needed and the complete shipping address.

N.C. Department of Health and Human Services
Division of Public Health

_____
Section/Branch

CONTRACT EXPENDITURE REPORT

_____
mo/yr of expenditure

Contract ID#

PO #

Contractor:_____

Total Expenditure: _____

Project Director: _____

Purpose: _____

ITEM DESCRIPTION	ITEM NO.	CONTRACTOR AMOUNT	DHHS AMOUNT
Company 2B01 ACCOUNT CENTER _____ _____ - _____ - _____ _____ _____ - _____ - _____			

As chief executive officer of the contracting organization, I hereby certify that the cost or units billed on this form were incurred and delivered according to the provisions of the contract. I further certify that any required matching expenditures have been incurred, and that to the best of my knowledge and belief we have complied with all laws, regulations and contractual provisions that are conditions of payment under this contract.

_____
Contractor Authorized Officer Signature and Date

_____
Contractor Fiscal Officer Signature and Date

Mail to: Appropriate Division Contract Administrator

_____
DHHS-DPH Contract Administrator Signature and Date

_____
DHHS -DPH Branch Head Signature and Date

(DHHS 2481 Revised 8/02/05)

Attachment I

Epilepsy and Neurological Disorders Program
Site Visit Form

Instructions: Each site visit should be documented using this worksheet. The monitor should indicate the reasons for the site visit, whether planned or unannounced, review data prior to the visit, and note any issues identified during the visit. If problems are noted, then this worksheet should be used to prepare a report to the monitor's supervisor for action.

Grantee:	Grant #:
Date:	Time:
Location:	
Monitor:	
Reason for Visit:	

Prior to Site Visit

Announced Visit		**Unannounced Visit**	
Actions Taken	Were Actions Completed?	Actions Taken	Were Actions Completed?
Notify recipient point of contact		Define objectives of visit, including documents to review	
Discuss objectives for visit, including document(s) to review		Review Grant File	
Review Grant File		Determine Issues to Discuss	
Determine Issues to Discuss			

During Site Visit

Announced Visit		**Unannounced Visit**	
Actions Taken	Were Actions Completed?	Actions Taken	Were Actions Completed?
Conduct entrance discussion with officials		Conduct entrance discussion with officials	
Observe project activities		Observe project activities	
Review program and financial records (see following pages for checklist)		Review program and financial records (see following pages for checklist)	
1. Compare to submitted reports		1. Compare to submitted reports	
2. Document differences		2. Document differences	
Other		Other	
Issues for Follow-up:			

After Site Visit

Announced Visit		**Unannounced Visit**	
Actions Taken	Were Actions Completed?	Actions Taken	Were Actions Completed?
Prepare Report		Prepare Report	
Document findings, whether positive or negative		Document findings, whether positive or negative	
Review and adjust monitoring plan if necessary		Review and adjust monitoring plan if necessary	
Other		Other	
Actions taken:			

Attachment V

Epilepsy and Neurological Disorders Program
Site Visit Form

Site Visit Financial Records Review Checklist			
1. Internal Controls	**Yes**	**No**	**Comments**
All expenditures made under grant are approved by the grantee program manager or someone who is familiar with the approved grant application and with the cost principles (A-87 and A-122).			
The grantee program manager approves only those expenditures that are: for activities approved in the budget and are allowable under the cost principles.			
Controls are in place that insures grant funds are available sufficient to cover expenditures.			
There is an accounting record for each grant received.			
Expenditures are posted to the accounting record as they occur.			
The accounting record tracks expenditures against the approved budget.			
Post-award changes in a grant budget have been approved by the funding agency and the budget has been adjusted in the accounting record.			
Required reports are filed within the established time frames.			
Documentation sufficient to determine the nature of grant expenditures and their allowability is kept as a part of the financial record.			
2. Use of Grant Funds			
Grant funds are not used to purchase land or buildings or improve land or buildings unless there is prior approval from the funding agency and it is allowable under grant terms.			
Special purpose equipment (an article costing more than $5,000) that is required to address specific grant objectives and that has been purchased with grant funds has been purchased in accordance with organizational policy insuring competitive prices.			
Grant funds are not used to purchase general purpose equipment (articles costing more than $5,000 and used for the general functions of the organization) such as office equipment and furnishings, telephone networks, information technology equipment and systems, air conditioning, reproduction and printing equipment and motor vehicles unless it is specifically identified as an allowable expenditure or there is prior approval from the awarding agency.			
If the grantee passes funds on to another organization, it is clear that it sub-grants these funds.			
A sub-grant award is on file that clearly identifies the activities supported by the subgrant, a budget, the assurances/ requirements that accompany federal funds, and payment provisions.			
The grantee monitors its sub-grantee for compliance with the conditions of the sub-grant award.			
3. Supplies and Materials			
Supplies and materials are charged to the grant in allowable fashion as approved in the budget.			
Only supplies and materials actually used for the grant objectives are charged as direct costs			
Supplies and materials are charged at their actual prices net any applicable credits.			

Attachment V

Epilepsy and Neurological Disorders Program
Site Visit Form

4. Equipment Inventory	Yes	No	Comments
Controls are in place to protect assets acquired with grant funds.			
Property/ equipment records are maintained that include a description, serial number, source, and acquisition cost and date.			
An inventory, up-dated within the last year, exists of equipment purchased with grant funds that includes the property record, its location, condition, and, if it was disposed of, the sale price or its fair market value.			
Control systems are in place to prevent loss, damage, or theft.			
Adequate maintenance procedures keep the property in good condition.			
5. Services and Reimbursable Costs			
Only allowable services supporting grant objectives are charged as direct costs of the grant as approved in the budget.			
The costs for travel, meals, conferences, training, and other incidental costs conform to cost principles and the organization's policies limiting these costs. Documentation includes the content of the event to which these costs are incidental and participants.			
Travel costs, including transportation, lodging, subsistence, and other costs associated with travel status, are charged to the grant when travel is essential for carrying out grant objectives and when costs do not exceed charges allowed by the organization in its normal operations.			
Only memberships, subscriptions, and professional activities related to grant objectives are charged to the grant.			
Costs identified as unallowable by federal circular, statute, regulation, or prohibited by the grant agreement are not charged to the grant.			
6. Records Retention			
Financial records, supporting documents, statistical records, and all other records pertinent to grant are retained for a period of three years after the submission of the final expenditure report , the required annual reports, or the record was used in response to an audit finding			

Site Visit Program Records Review Checklist

List Documents Reviewed	Comments
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	